



2007 UBO/UBU Conference

From Registration to Accounts Receivable - The Whole Can of Worms



Briefing: Ophthalmology and
Optometry Coding

Date: 21 March 2007

Time: 1110 - 1200

- Take the confusion out of coding Optometry and Ophthalmology services
- What constitutes a comprehensive eye exam
- What's the difference between using an E&M code and an Eye exam code
- Understand the elements of an Eye exam
- Bundling and unbundling of services
- Overview of E&M coding





Key Providers

(M.D.s or
D.O.s)
Medical
doctors who
specialize in
eye care

Ophthalmologist

O.D.s,
are
eye
docto
rs

Optometrist

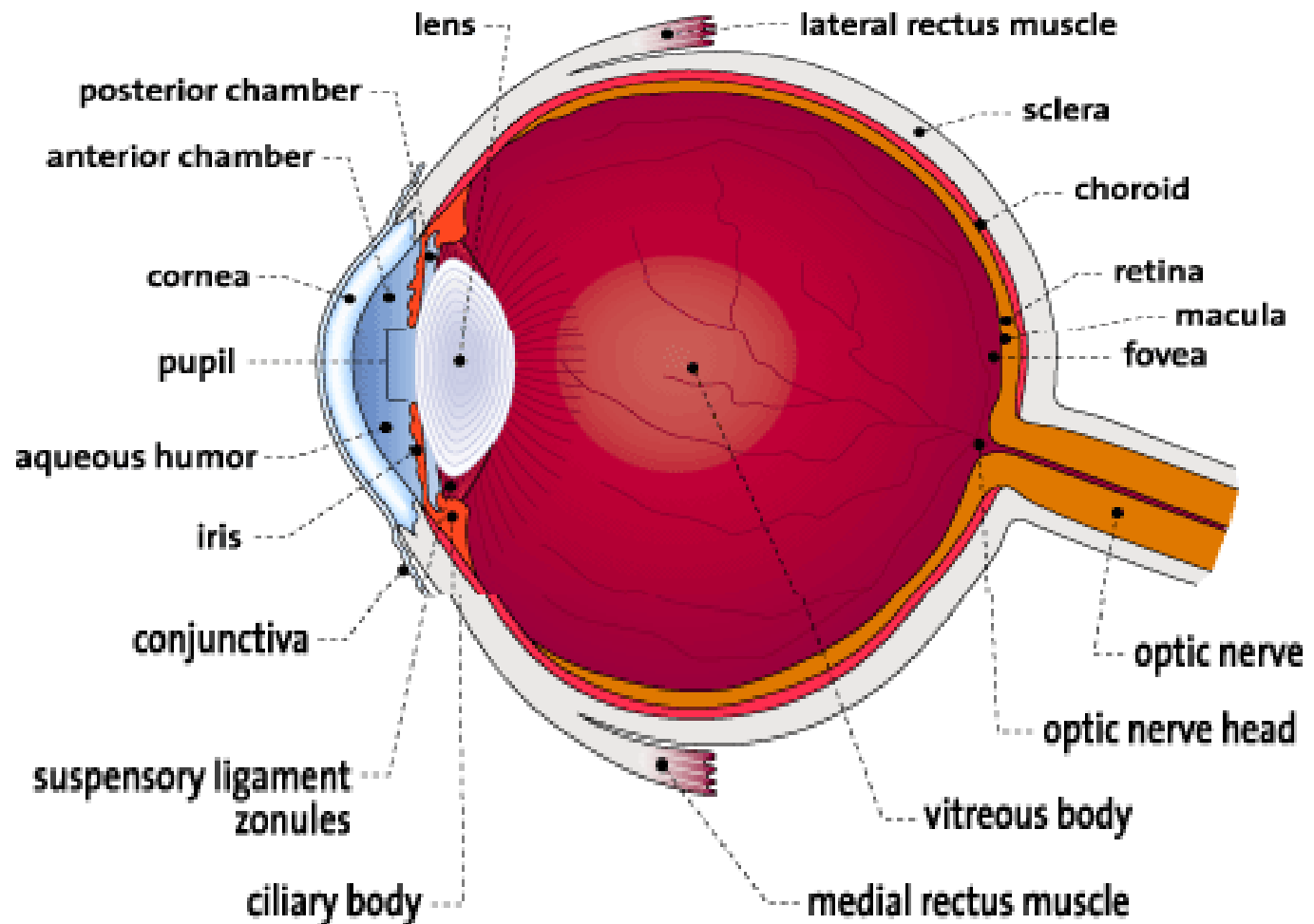
Eye care
profession
al; not a
doctor

Optometric or
ophthalmic
techs, assist
the above
providers,
experience
varies

Opticians

Technicians



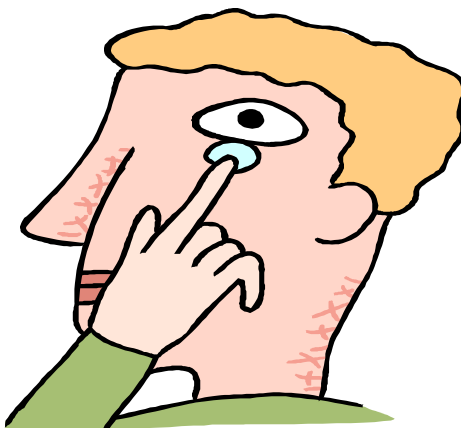


- ICD -9- CM (Eye Related Dx)
 - 360-379, V-codes
- CPT- 4 (Level I)
 - (e.g., 92002-92014,92015-92396, 65091-68899, 99241-99245)
- HCPCS Level II
 - (e.g.,G0117-G0118,S3000,S0810)



Diagnosis Coding Rules

- Medical Necessity is determined by the patient's diagnosis
- ICD-9 codes should "link" to each CPT code
- Code what you know to be fact (signs or symptoms), not suspected diagnoses
- Code chronic conditions when they apply to the patient's treatment (e.g., diabetes)

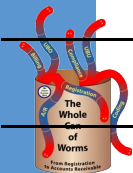




***“Encounters for DoD unique visits, such as aviation, periodic, or termination exams, are reported using V70.5 with the appropriate extender. Any condition diagnosed during the exam is listed as an additional diagnosis.”**

**MHS Coding Guidance: Professional Services and Specialty Coding Guidelines v2.0 2006 Services Coding Guidelines 2006 6.29.06*

V CODES	DESCRIPTION
V70.5 0	Armed Forces Medical Examination
V70.5 1	Aviation Examination
V70.5 2	Periodic Prevention Examination
V70.5 3	Occupational Examination
V70.5 4	Pre-Deployment Examination
V70.5 5	During Deployment Examination
V70.5 6	Post-Deployment Examination
V70.5 7	Fitness for Duty Examination
V70.5 8	Accession Examination
V70.5 9	Termination Examination





Diagnosis Coding Rules

Routine Eye Exams

- ***Routine Eye Exams;**
 - *****Without Complaints/Conditions***

Code Routine eye exams without complaints using V72.0 (*examination of eyes and vision*), *any condition identified during the exam, code as additional diagnosis.* **For Non-Active Duty Patients

- ******With Complaints/Conditions***

Code Routine eye exams with complaints by listing the *appropriate V code as the primary dx and complaints/conditions as secondary dx.*
*** *This applies to all patients, Active duty or Non-Active Duty*

*MHS Coding Guidance: Professional Services and Specialty Coding Guidelines v2.0
2006 Services Coding Guidelines 2006 6.29.06



- 377.43 Optic nerve hypoplasia (ONH);
 - Present at birth, the optic nerve did not fully develop
 - The exact cause is unknown, but it is frequently associated with gestational diabetes or fetal alcohol syndrome
 - Bilateral is more common than unilateral
 - Top 3 causes of impaired vision of children
 - 377.49 was previous code assignment for ONH



- 379.6x - New code series to report for inflammation of postprocedural bleb;
 - Post procedural blebs have 3 stages of infection;
 - Stage 1: bleb purulence
 - Stage 2: moderate inflammation of anterior segment
 - Stage 3: severe pain, vitritis and acute visual loss may occur
 - 379.6 Inflammation (infection) of post procedural bleb;
 - 379.60 *Unspecified*
 - 379.61 *Stage 1*
 - 379.62 *Stage 2*
 - 379.63 *Stage 3*



- Diagnosis Coding Rules
 - **250.5x** Diabetes with ophthalmic manifestations;
 - For ophthalmic manifestations due to Diabetes, the category **250.5x** code should be sequenced first, followed by the manifestation code(s)
 - Example: Patient was diagnosed with Diabetic Retinopathy and has a history of Diabetes type II
 - **250.52**- Diabetes with ophthalmic manifestations, type II
 - **362.01**- Background diabetic retinopathy



Coding Rules Special Conditions - Glaucoma Screening

- Glaucoma
 - The term applied to a group of eye diseases that gradually result in loss of vision by permanently damaging the optic nerve
 - Often is associated with increased Intraocular pressure (IOP)
 - The leading cause of irreversible blindness
- Screening for Glaucoma includes
 - A dilated eye examination with an intraocular pressure measurement
 - A direct ophthalmoscopy examination, or slit-lamp biomicroscopic examination



Special Conditions - Glaucoma Screening

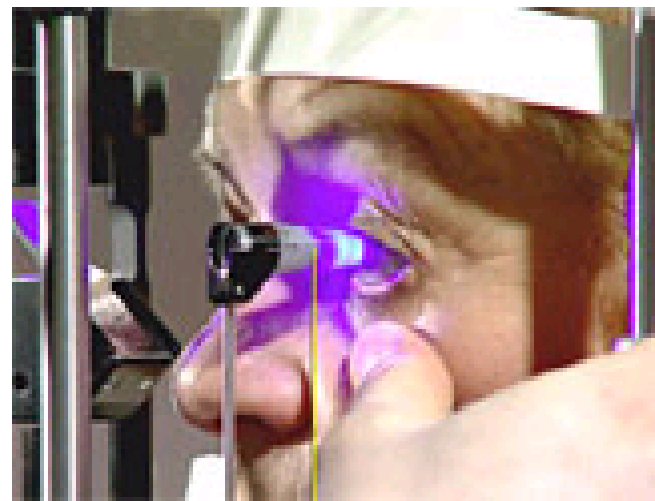
- Diagnosis Coding Rules
 - *Glaucoma screenings
 - For patients without a primary diagnosis of glaucoma, glaucoma screening is reported separately as V80.1
 - If this is part of an annual exam, list the annual examination V code of V70.5__2 followed by V80.1 as the second diagnosis

*MHS Coding Guidance: Professional Services and Specialty Coding Guidelines
v2.0 2006 Services Coding Guidelines 2006 6.29.06



Coding Rules Special Conditions- Glaucoma Screening

- **Procedural Coding Rules**
 - If a screening exam for glaucoma was the only ophthalmic service performed then code
 - G0117 Glaucoma screening for high-risk patients, furnished by an optometrist or ophthalmologist
 - OR
 - G0118 Glaucoma screening for high-risk patients, furnished under the direct supervision of an optometrist or ophthalmologist



- **Two types of exam codes**
 - Eye Exam and treatment codes
 - 92002 and 92004 for new patients
92012 and 92014 for established patients
 - E & M codes
 - Referrals
 - 99201 – 99205, for new patients (not seen in your clinic within 3 years)
 - 99212 – 99215 for established patients
 - Consults
 - 99241-99245



E&M vs. Eye Exam Codes

- There are specific documentation requirements for using E&M codes AND 92xxx Eye Exam and Treatment codes
- They are not the same.
- The requirements are more specific and stringent for E&M codes.
- While the documentation requirements for E&M codes will satisfy the requirements for 92xxx Eye exam and Treatment codes – the reverse is NOT true.



- **New Patients**

- **92002** Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate
- **92004** Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, one or more visits

- **Established Patients**

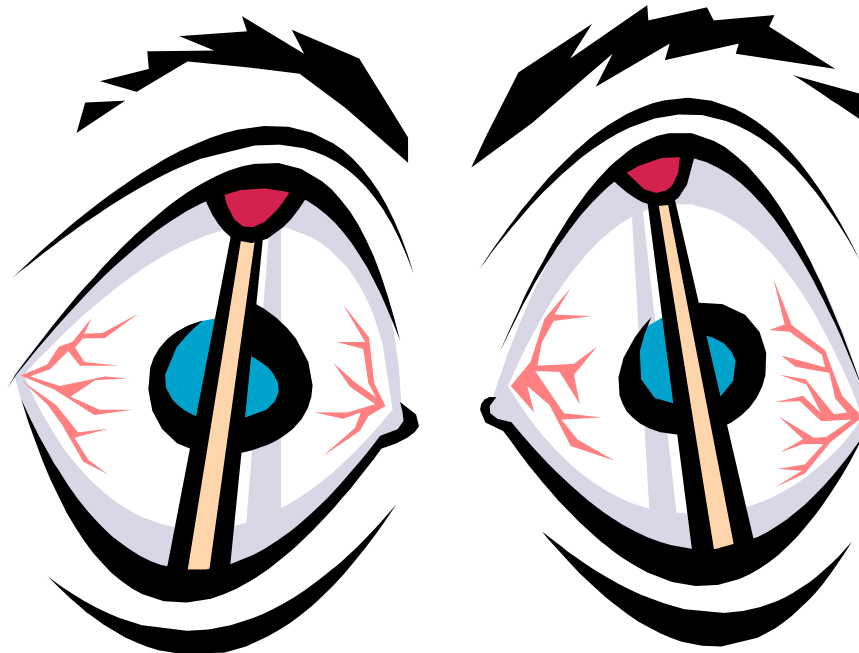
- **92012** Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate
- **92014** Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, one or more visits



- New = A patient who has not received services from an optometrist or ophthalmologist assigned to the clinic in the past three years



- Established = A patient who was treated by an optometrist or ophthalmologist up to three years ago, even if that provider is no longer assigned to the clinic, is an established patient



Comprehensive vs.

	Comprehensive Eye Codes	Intermediate Eye Codes
National Mandatory Components	<p>History</p> <p>General medical observation</p> <p>External examination</p> <p>Gross visual fields</p> <p>Basic sensorimotor evaluation</p> <p>Ophthalmoscopic examination</p>	<ul style="list-style-type: none"> • History • General medical observation • External ocular and adnexal examination <p>Other diagnostic procedures as indicated</p>
Optional Components	<p>Biomicroscopy</p> <p>Examination with cycloplegia</p> <p>Tonometry</p>	<p>May include mydriasis for ophthalmoscopy</p>
Miscellaneous Components	<p>Initiation of diagnostic and treatment programs</p>	



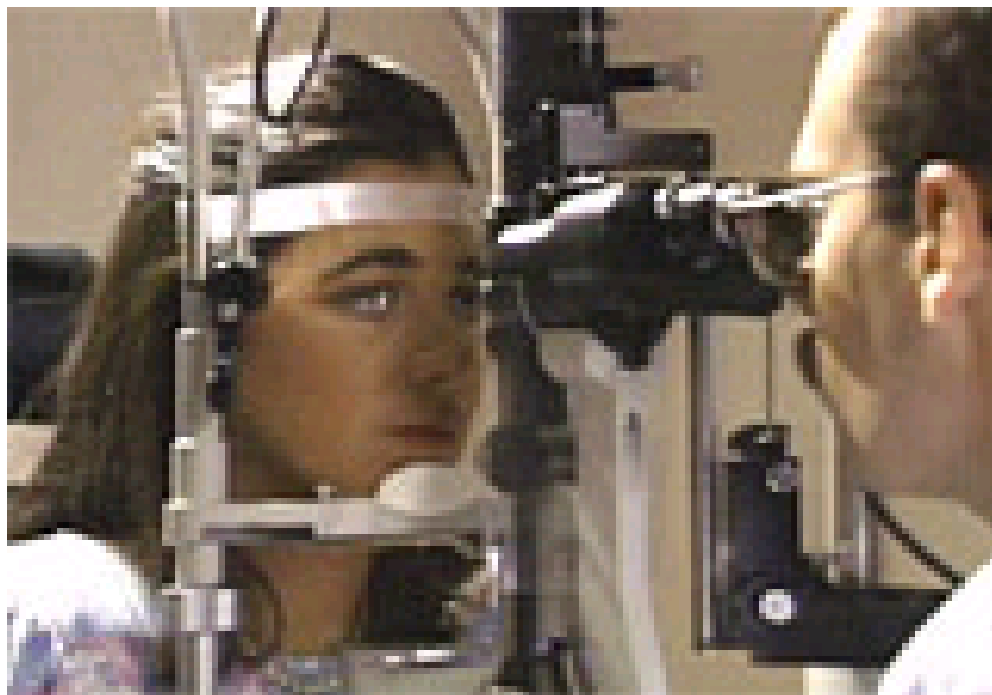
- There are 13 exam elements that must be documented to validate a coding level:

- Testing visual acuity
- Gross visual fields
- Ocular motility
- Pupils
- Iris
- Eyelids and adnexae
- Conjunctiva
- Cornea
- Anterior chamber
- Lens
- Intra-ocular pressure
- Retina
- Optic disc



General Ophthalmology Bundled Procedures

- Amsler grid
- Brightness acuity test (BAT)
- Corneal sensation
- Exophthalmometry
- General medical observation
- Glare test
- History
- Keratometry
- Laser interferometry
- Pachometry
- Potential acuity meter (PAM)
- Schirmer test
- Slit lamp tear film evaluation and transillumination



- If nine or more exam elements are documented = a comprehensive exam (92014 or 92004)
- If three to eight of the exam elements are documented = an intermediate exam (92012 or 92002)
- If less than three of these elements are documented
 - Use the lowest level E&M code
 - Level based on the provider's documentation (99201-new pt or 99212-99213 - est. pt)



An established patient came in with a sub-conjunctival hemorrhage;

In this situation the provider might record visual acuities, a brief slit lamp exam, and provide patient education.

None of these services have specific procedural codes assigned to them and less than three exam elements were performed.



E&M or Eye Exam Code?



ANSWER

E&M code (99212),
Provider performed
less than three exam
elements. This does
not meet the criteria
for Eye exam codes
920xx., must have
three or more exam
elements noted.





- ***Visual Screenings**

- *When doing an occupational health screening use
**99172 or **99173 (screening codes) for
optometry

- These codes are not to be used with the Eye exam codes
92002, 92004, 92012, and 92014 codes

*MHS Coding Guidance: Professional Services and Specialty
Coding Guidelines v2.0 2006 Services Coding Guidelines 2006
6.29.06

** CPT code 99172 must not be used with 99173





Ophthalmology CPT and Documentation Requirements

- **EXTENDED OPHTHALMOSCOPY WITH RETINAL DRAWING – 92225 (initial) / 92226 (subsequent)**
 - Use it only when you do a retinal evaluation to document pathology
 - It must be properly documented in the chart with complete, labeled retinal drawings
 - The documentation of follow-up services (92226) must include an assessment of the change from previous examinations

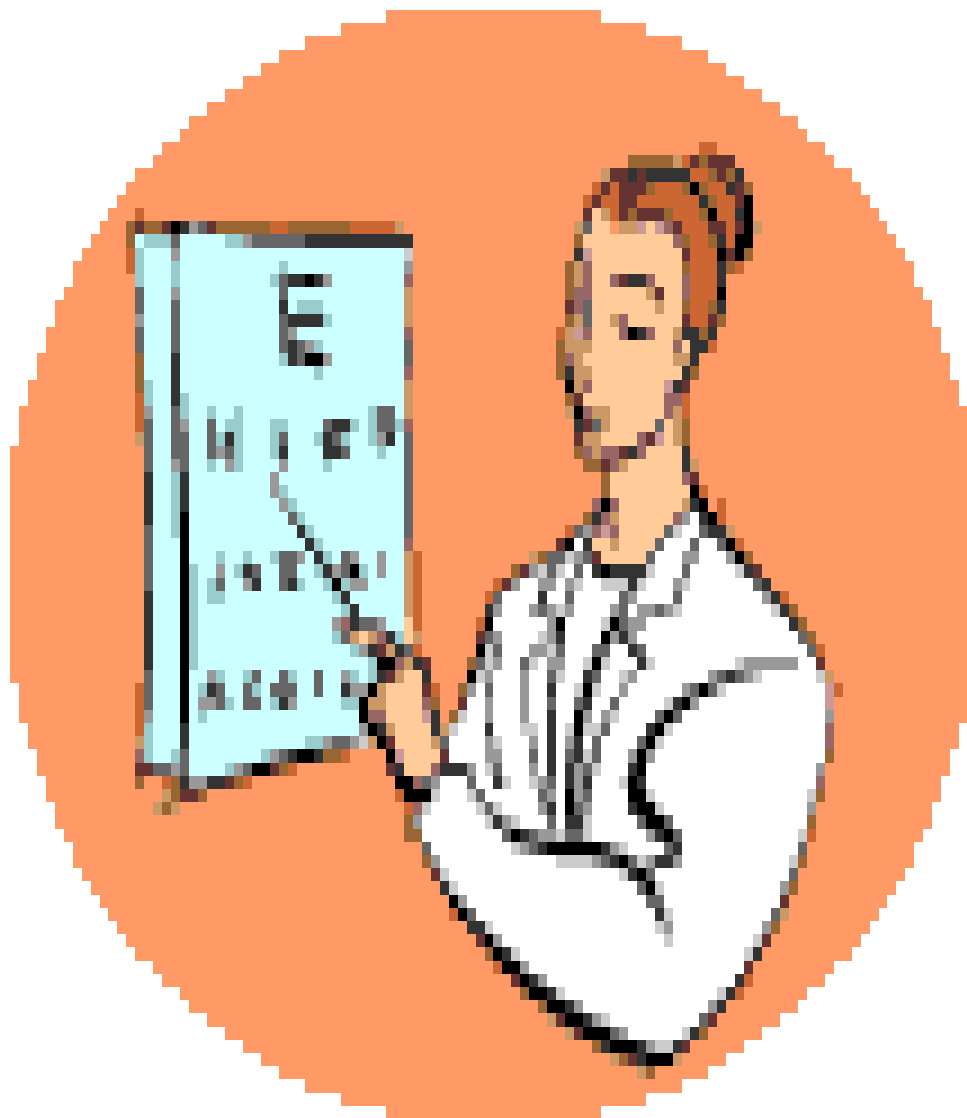


- **Visual Field Testing** is covered for diagnosis and treatment of abnormal signs, symptoms, disease or injury. Documentation in the record must establish medical necessity for the service including the frequency of the service.
 - 92081 Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (e.g., tangent screen, Autoplot)
 - 92082 Intermediate examination (e.g., at least 2 isopters on Goldmann perimeter or Humphrey suprathreshold automatic diagnostic test)
 - 92083 Extended examination (e.g., Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30°)





E&M Coding Overview



- An E&M code may be used when a patient is seen for a medical reason that requires either minimum or no eye examination procedure
- The most common instances when an E&M code would be used are:
 - Limited exams that do not meet the exam elements of an Intermediate Eye exam
 - But do meet the elements of a low level E&M code (e.g., follow-up conjunctivitis)
 - Highly complex or risk prone exams that meet the documentation elements of a level 4-5 E&M encounter



- **Based on 3 areas* of the DOCUMENTED note:**
 - History
 - Exam
 - Medical Decision Making

*Also known as 3 key components



HISTORY

α Chief Complaint

HPI (history of present illness) elements:

α Location α Severity α Timing γ Modifying factors
γ Quality γ Duration γ Context γ Associated signs & symptoms

Brief
(1-3)

Brief
(1-3)

Extended
(4 or
more)

Ext
(4 or
more)

ROS (review of systems):

γ Constitutional, γ Card/Vasc γ GU γ Psych γ Endo
(wt loss, etc) γ Resp γ Musculo γ Eyes γ GI
γ Integumentary γ Hem/Lymph
?Ears, nose, mouth, throat ?Neuro ?All/Immuno
?All others negative

None

Pertinent
to
problem 1
system

Extended
(2-9)

Comp
(10
+)

PFSH (past medical, family, social history) areas:

?Past history (patient's past experiences with illnesses,
operations injuries and treatments)
?Family history (review of medical events in patient's
family, including diseases which may be hereditary or
place the patient at risk)
?Social history (an age appropriate review of past &
current activities)

None

None

Pertinent
(1-2 hx
area)

Comp*
(2-3 hx
areas)

PROB
FOCUSED

EXP.
PROB
Focused

Detailed

COMP

Complete PFSH: 2 hx areas: a) Established patients - office (O/P)) b) Emergency visits c) Subsequent hospital visits

3 hx areas: a) New patients - office (O/P) b) Hospital observation c) Initial hospital care d) Consultations

e) Confirmatory consultations

** 10 or more systems, or some systems with statement "All others negative"



1997 Single System Exam- E&M

- Problem Focused = Limited exam of affected body area, 1-5 elements identified
- Expanded Problem Focused = Limited exam of affected body area and related areas, At least 6 elements identified
- Detailed = At least 9 elements identified
- Comprehensive = Perform all elements identified by a bullet



- Perhaps the most important component and the hardest to document completely;
 - Diagnosis & management options
 - Complexity of data reviewed
 - Risks of complications, morbidity, mortality





Number of Diagnoses or Management Options	Amount and/or Complexity of Data to be ordered/reviewed.	Risk of Significant Complications, Morbidity, and/or Mortality.	Type of Decision Making
Limited	Limited	Low	Low
Multiple	Multiple	Moderate	Moderate
Extended	Extended	High	High

LEVEL OF DECISION MAKING- Must meet 2 of the above 3 elements



Number of Diagnoses or

Management Options

Established Problem

- Stable (1)
- Improved (1)
- Worsening (2)

New Problem

- No additional work-up planned (3)
- Additional work-up planned (4)



Amount and/or Complexity of Data

Document any of the
following:
(value of 1)

- Ordering/reviewing lab test.
- Ordering/reviewing CPT-radiology defined services.
- Ordering/reviewing EKG, EEG, pulmonary function studies, etc.
- Discussion of test with performing physician.
- Decision to obtain patients old records.

Document any of the
following:
(value of 2)

- Independent reviewing of image, tracing, or specimen.
- Discussion of case with another health care provider
- Review and summarization of old records and/or obtaining history from someone other than the patient.



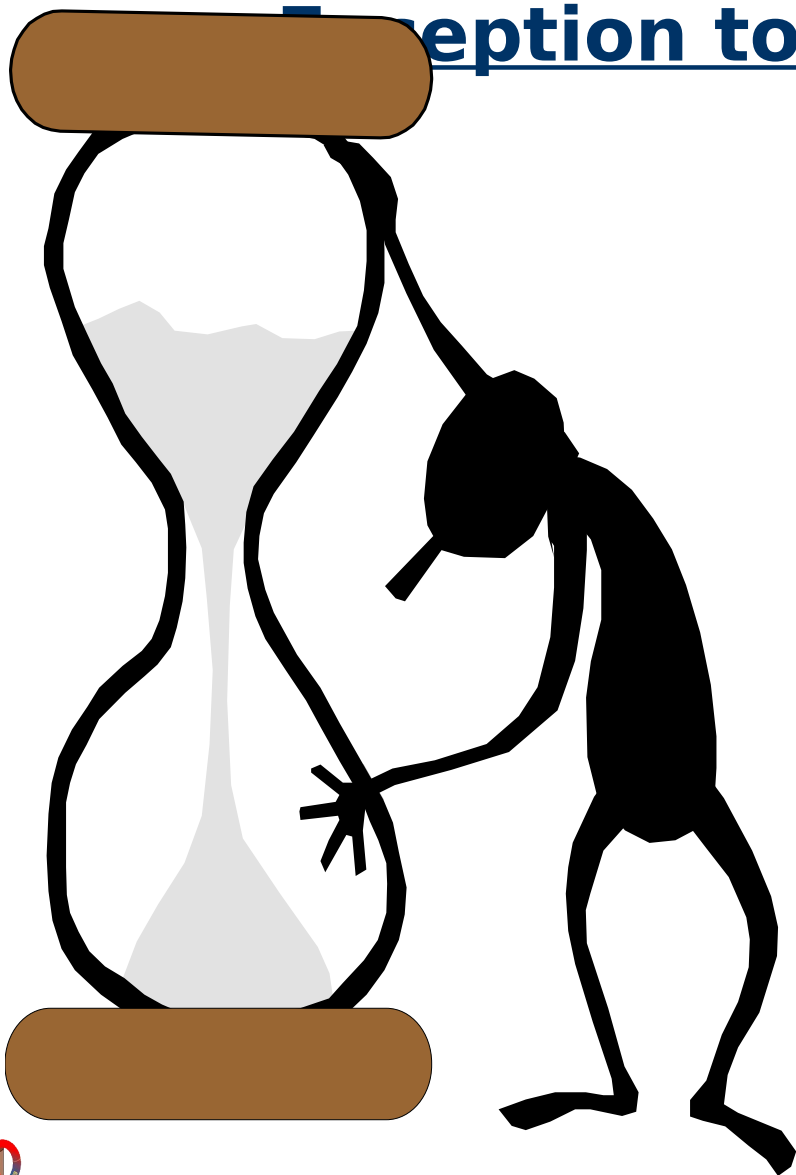


Risk of Complications and/or Morbidity or Mortality

Minimal	Low	Moderate	High
<ul style="list-style-type: none">• Self limited• Minor problem	<ul style="list-style-type: none">• Two or more self limited or minor problems.• One stable chronic illness.	<ul style="list-style-type: none">• One or more chronic illness with mild progression.• Undiagnosed new problem with uncertain prognosis.	<ul style="list-style-type: none">• Any chronic illness with severe exacerbation.• Illness that may pose a threat to life or body functions.• Change in neuro status.
<ul style="list-style-type: none">• Chest X- ray• Ultrasound	<ul style="list-style-type: none">• Skin biopsies.• Clinical lab test.• Pulmonary function test.	<ul style="list-style-type: none">• Deep needle biopsy.• Diagnostic endoscopies with no risk factors.• Obtain fluid from body cavity.	<ul style="list-style-type: none">• Cardiovascular imaging with identified risk factors.• Diagnostic endoscopies w/ identified risk factors.
<ul style="list-style-type: none">• Rest	<ul style="list-style-type: none">• Minor surgery no risk factors.• Over the counter drugs.• Physical therapy.	<ul style="list-style-type: none">• Minor surgery with risk factors.• Prescription drug management.	<ul style="list-style-type: none">• Major surgery with identified risk factors.• Emergency major surgery.• Parenteral controlled substances.



Exception to Key Component Rule



- Time can be used to choose level if greater than 50% of your time is spent in counseling and coordination of care.
- **MUST BE DOCUMENTED!**
 - **Total face-to-face or unit/floor time**
 - **Counseling time**
 - **Content of discussion**

- Consultation
 - Assign this visit type when physician renders **advice** or **opinion** about a specific problem at the **request** of another physician.



Documentation Requirements

- Consults must document request and reply
 - “Written or verbal request . . . may be made by a physician or other appropriate source and documented in the medical record”
 - “Consultant’s opinion and any services . . . ordered or performed **MUST** also be documented in the patient’s medical record **AND** communicated by written report to the requesting . . . source” [emphasis added]
- ER Consults
 - Usually referrals, not consults



- Consult = gives advice
 - Code for consults when the physician is asked to provide an opinion on diagnosis or treatment
- Referral = takes over patient care
 - Code for new or established patient visits if there is no intent to return care to the original provider for this condition



Consultation

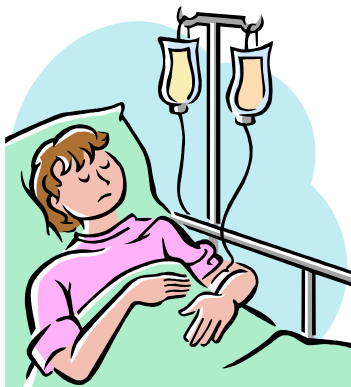
- Suspected problem
- Undetermined course of treatment
- Attending physician to decide who will manage patient care...this is undetermined at time of the consult
- Consulting physician must submit a written report to the requesting physician listing findings and suggestions

Referral (New Patient)

- Known problem
- Prescribed and known course of treatment
- When patient is referred to specialist, it is with the intent of transferring management of total care or a portion of patient care to the other provider
- No written letter or report is required



- Use 99251 - 99255 for initial consult per inpatient admission
 - New or established patient, new or established problem
 - Must still meet criteria for consult



*Additional visits during admission should be reported with the appropriate E&M code for subsequent hospital care (99231-99233)





Surgery



- Follow CPT surgical package
- Each procedure includes
 - Operation per se
 - Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia
 - Subsequent to the decision for surgery, one related E/M encounter on the date immediately prior to or on the date of procedure (including H&P)
 - “Typical” postoperative follow-up care



Pre and Postoperative Care

- Code surgery with modifier 54 if surgeon performs surgery only (e.g., S0810-55)
- Use E/M codes to describe preoperative services by other physicians
- Use modifier 55 with surgical procedure code to describe postoperative care (e.g., S0810-54)



Pre and Postoperative Care

- ICD-9-CM codes
 - V67.00 Follow-up exam following unspecified surgery
 - V67.09 Follow-up exam following other surgery
- E/M code 99024 Postoperative follow-up
 - To indicate that an evaluation and management (E/M) service was performed during a postoperative period for a reason(s) related to the original procedure



- Most commonly used modifiers in optometry or ophthalmology when unilateral codes are used; such as removal of foreign body
 - LT for left
 - RT for right
- Many of the procedures for the eye are inherently bilateral
- When one of these procedures is done on only one eye, add modifier -52, reduced services, as well as the modifier RT for right or LT for left



- Use modifier -57 for E/M day before or day of major surgery when decision for surgery made that day
 - Documentation must support decision for surgery
 - Use modifier -57 on day of surgery for global period of 90 days

- Use modifier -25 for E/M on day of minor procedure (global of 0 or 10 days)
 - Must be separately identifiable E/M beyond clearance for procedure



- Same procedure performed on each side of the body at the same time
 - Use Medicare Fee Schedule Data Base indicators for specific procedures
 - Reimbursement is 150% of allowable
- List procedure once with -50 modifier and 1 unit
 - Don't use -50 on Radiology codes, use units
 - Don't use modifier -50 on procedure described as bilateral



- Physicians use modifiers 80, 81, or 82
 - All reimbursed at 25% of the primary surgeon's fee
 - Use modifier 82 only in a teaching setting when no qualified resident is available
- PAs, and ANRSs use modifier AS for assistant
 - Paid at 21.25% of primary's allowable
 - Procedure must be listed on assistant-at-surgery list
 - If available, list NPPs nonbilling number in field 24K of CMS-1500



- Two surgeons work as primaries on part of a service described by a single CPT code
- Each surgeon bills same CPT code with modifier 62
- Reimbursement is 62.5% of allowable for single surgeon



- Key Providers
- Diagnosis Coding Rules
- Diagnosis Coding Rules-DoD Extender Codes
- 2007 ICD-9-CM Changes
- Coding Rules for Special Conditions
- E&M vs. Eye Exam Codes
- Exam elements
- When to Use
Eye codes vs. E&M
- Visit Types
- Bundled Procedures
- Surgical Package



- 2007 AMA Current Procedural Terminology(CPT)
- 2007 ICD-9-CM Volumes 1 & 2
- CPT Assistant
- Military Health System Coding Guidance:Professional Services and Specialty Coding Guidelines,Version 2.0,Unified Biostatistical Utility , 2006
- Center for Medicare and Medicaid Services (CMS)
- Global Services data for Surgery, American College of Surgeons (www.facs.org)
- Eyeworld (www.eyeworld.org)
- Allaboutvision.com
- Ophthalmology Management

